# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| **Type of Requestor:** (x) HCP ( ) IE ( ) IC | **Response Timely Filed?** (x) Yes ( ) No |
|---|---|
| Requestor's Name and Address<br>Dr. B<br>7125 Marvin D. Love #107<br>Dallas, TX 75237 | MDR Tracking No.: M4-04-0103-01<br>TWCC No.: ___<br>Injured Employee's Name: ___ |
| Respondent's Name and Address<br>American Protection Insurance<br>c/o Flahive Ogden & Latson<br>Box 39 | Date of Injury: ___<br>Employer's Name: ___<br>Insurance Carrier's No.: 4650160076 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 12/23/02 | 01/06/03 | 97545-WH-AP | $1,152.00 | |
| 12/23/02 | 01/06/03 | 97546-WH-AP | $1,152.00 | |
| | | | | |
| | | | | |

## PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 08/25/03 states in part, "…We have not received a response from the carrier for our attached billing. Our second request with demand letter was sent to carrier via certified mail and according to the USPS Tracing Confirmation Log, the carrier received on May 30, 2003…"

## PART IV: RESPONDENT'S POSITION SUMMARY

The respondent did not submit a position summary; however, the response to the TWCC-60 indicates the respondent's rational for the disputed dates of service as "Treatment deemed unnecessary and unreasonable per peer review". The carrier did not submit any EOBs or a copy of the peer review with their response.

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Codes 97545-WH-AP and 97546-WH-AP for dates of service 12/23/02, 12/24/02, 12/26/02, 12/27/02, 12/30/02, 12/31/02, 01/02/03, 03/03/03, and 01/06/03. EOBs were not submitted by either party. Although the requestor submitted a "demand letter" and a copy of a "Track & Confirm" from USPS, the submitted documentation does not confirm that the correct carrier received the request for reconsideration. A copy of the signed green card was not submitted; therefore, per Rule 133.307(e)(2)(B) the requestor did not submit convincing evidence that the respondent received the request for reconsideration. Reimbursement is not recommended.

**PART VI: DETAIL FINDINGS (If needed)**

| Date of Service | CPT Code | Amt in Dispute | Amt Due | Date of Service | CPT Code | Amt in Dispute | Amt Due |
|---|---|---|---|---|---|---|---|
| 12/23/2002 | 97545-WH-AP | $128.00 | $0.00 | 1/3/2003 | 97545-WH-AP | $128.00 | $0.00 |
| 12/23/2002 | 97546-WH-AP | $128.00 | $0.00 | 1/3/2003 | 97546-WH-AP | $128.00 | $0.00 |
| 12/24/2002 | 97545-WH-AP | $128.00 | $0.00 | 1/6/2003 | 97545-WH-AP | $128.00 | $0.00 |
| 12/24/2002 | 97546-WH-AP | $128.00 | $0.00 | 1/6/2003 | 97546-WH-AP | $128.00 | $0.00 |
| 12/26/2002 | 97545-WH-AP | $128.00 | $0.00 | | | | |
| 12/26/2002 | 97546-WH-AP | $128.00 | $0.00 | | | | |
| 12/27/2002 | 97545-WH-AP | $128.00 | $0.00 | | | | |
| 12/27/2002 | 97546-WH-AP | $128.00 | $0.00 | | | | |
| 12/30/2002 | 97545-WH-AP | $128.00 | $0.00 | | | | |
| 12/30/2002 | 97546-WH-AP | $128.00 | $0.00 | | | | |
| 12/31/2002 | 97545-WH-AP | $128.00 | $0.00 | | | | |
| 12/31/2002 | 97546-WH-AP | $128.00 | $0.00 | | | | |
| 1/2/2003 | 97545-WH-AP | $128.00 | $0.00 | | | | |
| 1/2/2003 | 97546-WH-AP | $128.00 | $0.00 | | | **Total Left Column:** | $2,304.00 |
| | | | | | | **Total Amount Due:** | $0.00 |

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

**Ordered by:**

| Authorized Signature | Marguerite Foster | December 22, 2004 |
|---|---|---|
| | Typed Name | Date of Order |

**PART VIII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____